BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
LOUIS JAMES NITSOS, M.D.	)	**File No. 02-2008-189113**
	)	
Physician's and Surgeon's Certificate No. G75023	)	
	)	
	)	
Respondent.	)	
	)	

DECISION EFFECTIVE DATE AFTER JUDICIAL REVIEW

On March 16, 2010, the Medical Board of California issued its Decision in the Matter of the Accusation against Louis James Nitsos, M.D. with an effective date of April 15, 2010.

On April 7, 2010, respondent filed a Verified Petition for Writ of Administrative Mandate and Request for Stay of Decision and Order of Medical Board in the Superior Court of the State of California for the County of San Francisco, Case No. CPF 10-510341. On May 13, 2010, the Superior Court issued an Order Staying Administrative Action staying the Medical Board's Decision until August 13, 2010 with an extension of Stay issued on October 20, 2010 for a Stay granted through December 3, 2010.

On March 28, 2011, the Superior Court issued a Judgment Denying Petition for Writ of Administrative Mandate denying respondent's petition. Since no additional Stays have been granted by any higher Court, the Stay, issued on October 20, 2010, was dissolved and the **Decision became effective March 28, 2011.**

Albert J. Garcia (SBN 70917)
Attorney At Law
2000 Powell Street, Suite 1290
Emeryville, California 94608
Telephone: (510) 848-5190

Attorney for Petitioner,
Louis Nitsos, MD

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

Louis Nitsos, MD, Petitioner, vs. Medical Board of California, Respondent.	Case No. CPF-10-510341 ~~[Proposed]~~ Order : (1) Continuing Hearing from November 5, 2010 to December 3, 2010, and (2) Extending of Stay of Respondent's Decision to December 3, 2010.

Based on Stipulation of counsel, IT IS HEREBY ORDERED that the hearing on the Petition for Writ of Administrative Mandate is continued from November 5, 2010 to December 3, 2010, and the stay of respondent's decision is extended to December 3, 2010.

Dated: OCT 20 2010

PETER J. BUSCH

Hon. Peter J. Busch,
Judge of the Superior Court

Albert J. Garcia (SBN 70917)
Attorney At Law
2000 Powell Street, Suite 1290
Emeryville, California 94608
Telephone: (510) 848-5190

ENDORSED
FILED
San Francisco County Superior Court

MAY 13 2010

CLERK OF THE COURT
BY: JOCELYN C. ROQUE
Deputy Clerk

Attorney for Petitioner,
Louis Nitsos, MD

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

Louis Nitsos, MD, Petitioner, vs. Medical Board of California, Respondent.	Case No. CPF-10-510341 ~~[Proposed]~~ (JCR) Order Staying Administrative Action Date: May 13, 2010 Time: 11:00 a.m. Dept. 301

Petitioner's Ex Parte Application for Stay Order came on for hearing on May 13, 2010. Albert J. Garcia appeared as attorney for petitioner, and Deputy Attorney General W. David Corrick appeared on behalf of respondent Medical Board of California.

Having considered the papers in support and in opposition to the Application for Stay Order, and the arguments of counsel, THE COURT HEREBY ORDERS the decision of respondent (MBC Case No. 2008070329) stayed until August 13, 2010. ~~Respondent is ordered not to disclose its decision to the public, and is further ordered to withdraw any previous public disclosures pending judgment herein.~~

(JCR)

Dated: MAY 13 2010

PETER J. BUSCH

Honorable Peter J. Busch,
Judge of the Superior Court

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
LOUIS JAMES NITSOS, M.D.	MBC No. 02-2008-189113
Physician's & Surgeon's Certificate No. G 75023	
Respondent	

ORDER GRANTING STAY

Deputy Attorney General W. David Corrick has filed a request for a stay of execution of the Decision in this matter with an effective date of April 15, 2010.

Execution is stayed until May 13, 2010.

This stay is granted solely for the purpose of allowing the respondent to file a Petition for Reconsideration and the Medical Board of California time to review and consider the Petition for Reconsideration.

DATED: April 13, 2010.

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation against:	OAH No: 2008070329
LOUIS JAMES NITSOS, M.D.	File No: 02-2008-189113
Physician's and Surgeon's Certificate No. G 75023	
Respondent.	

DECISION

The Proposed Decision of Marilyn A. Woollard, Administrative Law Judge, dated February 16, 2010, in San Diego, is attached hereto. Said decision is hereby amended, pursuant to Government Code Section 11517 (c)(2)(C) to correct technical or minor changes that does not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

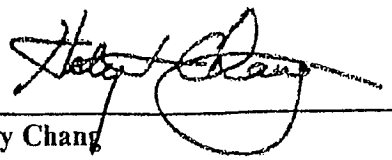
Page 1, Case Number should read, "02-2008-189113."

The Proposed Decision as amended is hereby accepted and adopted as the Decision and Order by the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 15, 2010.

DATED March 16, 2010.

MEDICAL BOARD OF CALIFORNIA



Hedy Chang
Chair, Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LOUIS JAMES NITSOS, M.D. Danville, California 90027 Physician and Surgeon's Certificate Number G 75023 Petitioner.	Case No. 17-2002-133504 OAH Case No. 2008070329

PROPOSED DECISION

Administrative Law Judge (ALJ) Marilyn A. Woollard, Office of Administrative Hearings (OAH), State of California, heard this matter in Sacramento, California, on August 11, 12, 21, 2009, and on October 21, and 22, 2009.[1]

Deputy Attorney General W. David Corrick represented complainant Barbara Johnson in her official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Attorney Albert Garcia represented respondent Louis James Nitsos, M.D., who was present all on hearing days except October 22, 2009.

Oral and documentary evidence was presented. At the conclusion of the hearing, the record remained open to allow counsel an opportunity to submit written closing arguments.

On January 13, 2010, OAH received written closing arguments from attorneys for both parties. The record was closed and the matter was submitted for decision.

[1] On August 21, 2009 and October 22, 2009, the testimony of witnesses Dr. Louis Jambour (cross-examination) and Mr. Charles Wilcox was taken via videoconferencing, from OAH offices in Los Angeles and San Diego.

FACTUAL FINDINGS

1. On August 25, 1992, the Board issued Physician's and Surgeon's Certificate Number G75023 to respondent. Respondent's license is in full force and will expire on May 31, 2010, unless renewed, revoked or suspended.

2. On June 13, 2008, complainant filed an Accusation against respondent, and requested that his license be disciplined for alleged unprofessional conduct in violation of Business and Professions Code sections 2234, subdivision (a), 2238 and 2239, subdivision (a), in conjunction with Health and Safety Code sections 11170 and 11055, subdivision (c).[2] Specifically, complainant alleged that, on or about December 19, 2007, respondent used, administered, or furnished to himself Fentanyl, a Schedule II Controlled Substance.

3. On June 20, 2008, respondent filed his Notice of Defense and request for hearing.

4. Thereafter, the matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500, et. seq.

Respondent's Participation in Diversion Program

5. Respondent received his M.D. degree from the Indiana University School of Medicine in 1991. After serving as a physician in the Navy, respondent began his residency in anesthesiology at the University of California Davis Medical Center (1994) and completed it at the Yale University Medical Center (1995 through 1997). Respondent has been certified in anesthesiology by the American Board of Anesthesiology since 1999.

6. From November 2001 through January 2003, respondent worked as an anesthesiologist at Metropolitan Anesthesia Consultants (Metropolitan), with staff privileges at Mercy San Juan Hospital and Mercy San Juan Surgery Center in Carmichael, California. In March 2002, a pharmacist reported that respondent used excessive amounts of Sufentanil from his drug kit. Metropolitan placed respondent on probation, required him to submit to random urine testing, and directed him to stop using Sufentanil in surgery.

[2] Unless otherwise indicated, all statutory references are to the Business and Professions Code.

On January 9, 2003, respondent contacted the Board's Diversion Program (Diversion) and reported he had a drug problem. At the time, respondent's case was scheduled for discussion by Metropolitan's Medical Executive Committee for his failure to comply with probation.

On January 16, 2003, respondent completed his formal application for participation in Diversion. Respondent reported that Sufentanil was his primary drug of abuse, that he concurrently used Fentanyl, and that he had used these drugs intravenously for approximately 14 months, three to four times a day. Respondent reported having taken Ritalin in elementary school for attention deficit disorder, and having used steroids in high school. Respondent signed an "Agreement During Evaluation Process" with Diversion, subjecting himself to various conditions, including providing four random urinalysis tests a month, and participating in an intense schedule of Diversion group and Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings each week.

On January 27, 2003, respondent entered treatment at the Betty Ford Center for 90 days.

7. In June 2003, respondent met with the Diversion Evaluation Committee (DEC), which approved his participation in Diversion. Respondent formally entered Diversion on July 9, 2003, the date he signed his "Physician Diversion Program Agreement" (Agreement), agreeing to participate in Diversion for five years, with additional time if necessary for his recovery. As part of his Agreement, respondent agreed not to practice medicine until approved by Diversion and that he would begin to take Naltrexone, an opioid antagonist, two weeks prior to returning to work. Respondent was subject to various conditions, including providing four observed random urinalysis tests a month, and participating in two facilitated Diversion group meetings and three AA or NA meetings each week.

Respondent's Diversion Agreement was amended by the DEC on several occasions. In approximately June 2005, respondent began taking Naltrexone and was authorized to return to work on a part-time basis with Dameron Hospital Association in Stockton. Respondent's part-time hours were incrementally increased and he was eventually returned to a full-time work schedule.

In early 2006, Diversion discovered that respondent had unilaterally stopped taking Naltrexone on a daily basis. Respondent testified that he stopped taking Naltrexone for several months in the summer of 2005. When confronted about his violation of Diversion, respondent said he took Naltrexone only on the days he was working because he was concerned about its side effects. Respondent apologized, resumed daily Naltrexone consumption, and discussed the issue in his group meetings. On September 16, 2006, an Amendment to the Agreement added a provision that respondent's urine would be tested for "steroid/naltrexone screens"

upon request. It was expected that respondent's urine would test positive for Naltrexone on all such tests.

In late January 2006, respondent moved to Palm Springs to be closer to his children, and worked full-time at Desert Regional Medical Center. In approximately March 2007, respondent returned to northern California, again following his children, where he worked full time at San Joaquin General Hospital (SJGH) in French Camp.[3]

8. *Positive Amphetamine/Methamphetamine Drug Tests*: Prior to the December 19, 2007 test at issue, respondent had three positive drugs tests: on December 20, 2006 (amphetamine and methamphetamine), on January 5, 2007 (methamphetamines), and on March 15, 2007 (amphetamine and methamphetamine). As to each of these tests, respondent denied that he had used any illegal drugs and told his Diversion case manager he believed that "false positives" were caused by the body-building supplements he was taking. At his request, the December 2006 positive urine test was retested by a different drug screening lab, which determined that his urine was negative for controlled substances.

On March 15, 2007, following his third positive test for these substances, respondent's Diversion case manager Jim Thiel instructed respondent to "complete an autopsy of the products that he ingests so that we can come to some conclusions on what is causing his positive tests. I also emphasized that [sic] need to be consistent in his Naltrexone usage." Respondent complied. On March 26, 2007, Mr. Thiel reported that he had forwarded respondent's list of protein and vitamin supplements taken to Quest Diagnostic Laboratories "to see if they could identify which supplement could be giving us this positive test result. Quest Labs called back and stated that it was not possible to see which was the problem." Once informed of this, respondent agreed to immediately stop using all protein supplements except protein powder.

Respondent attended a DEC meeting on May 14, 2007, at which his positive drug tests were discussed. Following this meeting, Diversion Program Administrator Frank Valine reported that the DEC was pleased that respondent had discarded his use of weight training supplements and put his recovery first.

With the exception of the incidents discussed above, the DEC found respondent to be working appropriately toward his recovery.

---

[3] On two occasions in March 2006, shortly after he moved to southern California, respondent missed two random drug tests and did not participate in several Diversion group meetings. He promptly reported these events to his Diversion case manager and explained that his missed tests were due to not having a local specimen collector and having to drive several hours to San Bernardino for meetings and collections.

Respondent's Resignation/Termination from Diversion

9. The Board's Diversion Program was scheduled to sunset in July of 2008. Respondent's annual DEC meeting of December 7, 2007 addressed what he needed to do to complete his five year Diversion commitment. There is no written record of this meeting. During this meeting, DEC told respondent they wanted him to continue taking Naltrexone indefinitely and instructed him to contact SJGH's Well-Being Committee to make arrangements for this continued Naltrexone usage, before they would agree to formally terminate him from Diversion. Respondent was concerned about this requirement. He testified that SJGH did not have a Well-Being Committee, and he waited for its next ad hoc meeting to discuss this issue.

10. On December 19, 2007, respondent was notified by certified specimen collector Joaquin Vivero that he needed to provide a urine sample for analysis. Respondent complied with this request. At approximately 4:40 p.m. that day, Mr. Vivero observed respondent urinate into two separate specimen bottles. Mr. Vivero then sealed the bottles with tamper-proof evidence tape, placed the specimen bottles into a tamper-proof bag, and placed the tamper-proof bag into a tamper-proof laboratory pack, which he forwarded to Quest Diagnostic Laboratory (Quest) in Norristown, Pennsylvania via FedEx delivery service. Respondent's urine sample was received by Quest on December 21, 2007, where it was analyzed for a variety of substances, including Fentanyl and Naltrexone.[4] Respondent's urine tested positive for Fentanyl, Naltrexone, and Naltrexone's metabolite.

On approximately January 2, 2008, after receiving these test results, Diversion instructed respondent to: immediately cease work for an indefinite period, enter an inpatient treatment facility, and have an assessment "to determine whether he should ever practice anesthesiology."

On January 2, 2008, respondent faxed a letter to Wally George, his Diversion case manager, advising that he was "officially resigning" from the program as of this date and revoking consent to discuss his participation in Diversion with anyone. This same day, respondent refused to provide a random urine sample to Mr. Vivero. After resigning, respondent stopped taking Naltrexone.

11. On January 3, 2008, respondent was notified by Mr. Valine that he had been terminated from Diversion effective January 3, 2008, "for reasons other than successful completion of the Diversion Program," and that a copy of this notification was sent to the Board's Enforcement Program. Mr. Valine testified that Diversion considered this to be a relapse and would not have terminated respondent if he had agreed to comply with its instructions. By letter of this same date, Mr. Valine advised

[4] In his trial brief, respondent challenged the manner in which his urine was collected. At hearing, respondent's counsel stipulated that this was not at issue.

the Board's Enforcement Chief of respondent's termination from Diversion and the DEC's "conclusion that he is a threat to the public and his patients..." Respondent's case was transferred to Enforcement for immediate action.[5]

Respondent's December 19, 2007 Urine Sample and Analysis

12. The parties stipulated: (1) that the December 19, 2007, urine collection at issue in this hearing was properly performed; and (2) that from the time of collection, through the time the urinalysis was completed, which resulted in a three-page report dated December 29, 2007, certified by James Walczak, the proper and appropriate chain-of-custody relative to respondent's December 19, 2007, urine sample was maintained at all times. Further, respondent stipulated that he does not dispute the fact that the results of the urine sample set forth in the three-page report, accession number 897342Q, were solely derived from his December 19, 2007, urine sample.

13. *Testing On December 19, 2007 Urine Sample*: Once at Quest, an aliquot (small portion) of respondent's December 19, 2007 urine specimen (hereafter, specimen or sample) was qualitatively screened for the presence of Fentanyl using Enzyme Linked Immunosorbent Assay (ELISA). Based upon a positive Fentanyl finding at a threshold of 300 picograms per milliliter (pg/mL), a confirmatory analysis for Fentanyl, Naltrexone and its metabolite was then performed using Gas Chromatography/Mass Spectrometry (GC/MS).[6] The threshold for a positive test for each of these substances on GC/MS is 500 pg/mL. In Quest's three-page December 29, 2007 Laboratory Report, Mr. Walczak reported that respondent's December 19, 2007, urine sample was quantitatively positive for the following substances:

Naltrexone	752 ng/mL
Naltrexone Metabolite	1817 ng/mL
Fentanyl	622 pg/mL[7]

This analysis did not determine whether Fentanyl's metabolite, Norfenanyl, was also present to indicate that the substance had been metabolized by respondent's liver.

---

[5] Respondent subsequently refused to authorize the release of his Diversion records to SJGH, and never returned to work at this facility.

[6] Due to their different thresholds, a test that is positive on the ELIZA screen may be negative once subjected to GC/MS analysis.

[7] A nanogram (ng) is a billionth of a gram. A picogram (pg) is a trillionth of a gram. A picogram is the smallest laboratory measurement Quest uses to detect these substances.

14. *Quest's November 20, 2008 Retest of December 19, 2007 Urine Sample:* On November 20, 2008, on its own initiative, Quest conducted a retest of respondent's December 19, 2007 urine sample and, for the first time, analyzed whether Norfenanyl was present in respondent's urine on December 19, 2007.

As supported by the expert testimony of Dr. Louis Jabour and corroborated by documentary evidence, Quest maintained proper storage of, and chain-of-custody for, respondent's December 19, 2007, urine specimen from the time it was received by Quest on December 21, 2007, until it was retested on November 20, 2008.

On June 26, 2009, Quest's certifying scientist Suzanne Churgai prepared a Laboratory Report for the Board on respondent's December 19, 2007, urine sample, based upon its November 2008 retest. Final results for respondent's urine were positive for both Fentanyl and Norfentanyl, with the following quantitative results:

Fentanyl	568 pg/mL
Norfentanyl	4220 pg/mL

Respondent's Testimony Regarding December 19, 2007 Sample

15. On December 19, 2007, respondent was on SJGH's anesthesia call schedule as the hospital's primary or "first on-call" anesthesiologist. He worked from 7:00 a.m. that morning until 7:00 a.m. the following day, and was involved in 10 to 12 cases. Mr. Vivero typically called him to schedule his urine draw sometime between 10:00 a.m. and 2:00 p.m., but respondent did not recall exactly when he was notified of the urine test on this day.

Respondent denied that he intentionally ingested Fentanyl at any time from December 1 through 19, 2007, or at any time while in Diversion. His sobriety date for drugs is March 2002. Respondent offered redacted operative records from three surgeries in which he participated on December 19, 2007. These records demonstrate that respondent was the relief anesthesiologist for two surgeries and the primary anesthesiologist in a third surgery, and that Fetanyl was administered in only one of these surgeries. The anesthesia record for that surgery established that Fentanyl was administered thirty minutes before respondent assumed his duties, at 1500 hours, and it was not re-administered during the surgery. Respondent was the relief anesthesiologist in another surgery that began at 1420 hours, but the anesthesia agents listed are propofol/versed, not Fentanyl. Sometime that morning, respondent was the anesthesiologist for a cesarean section. The records provided indicate only that an unspecified spinal anesthesia was used.

Respondent testified that Fentanyl is commonly used during surgical procedures for pain and as an adjunct to general anesthesia, and that he generally uses it for spinals. He typically wears gloves at the beginning of an induction and intubation; after this process, he does not wear gloves unless there is a risk of

contamination with blood or body fluids. During procedures, respondent will add various medications through IV ports. In addition to his surgical duties, one of respondent's duties as the first on-call anesthesiologist is to set up the operating rooms with medications. Respondent does not wear gloves when he sets up medications. On direct examination, respondent testified that, based upon the fact that he was the first on-call on December 19, 2007, he was "100 percent certain" he handled Fentanyl on this date. Respondent later clarified that he had no recollection of handling Fentanyl that day; his belief that he handled it was based upon his general practice.

Fentanyl comes in a glass vial container [ampule]. The top is popped off with the thumb, the vial is inverted and a syringe is inserted.[8] When respondent opens a vial, occasionally some Fentanyl is retained in the upper glass and he gets "splashed." Respondent did not recall that splashing occurs that often, just that it can occur. Respondent testified that he does not recall any specific incident of splashing on December 19, 2007. When a splash occurs, respondent does not try to wash it off because it is such a minute amount [1 – 2 ccs] that it will not cause a therapeutic blood level.

Respondent estimated that in 2007, he submitted approximately five other urine samples to Mr. Vivero after he was the on-call anesthesiologist engaged in surgical procedures. From July 2005 through December 2007, respondent estimated he was urine tested approximately 20 times post-surgery. He acknowledged that none of these urine tests was positive for Fentanyl. He agreed that Fentanyl is the primary drug abused by anesthesiologists. He was not aware of any anesthesiologists who had a false positive from skin absorption of Fentanyl.

Respondent testified that he also provided urine samples to Mr. Vivero on December 22 and 27, 2007. His testimony was corroborated by his cancelled checks to Mr. Vivero and Quest on these dates. Respondent did not learn until January 2, 2008 that his December 19, 2007, test was positive; he was never notified that these subsequent tests were positive. On January 1, 2008, Diversion told him to stop working immediately and to arrange to attend inpatient treatment. He was never given the option to retest his urine sample.

Expert Testimony

16. *Testimony of Louis Jambour, Ph.D.*: Dr. Jambour earned a Bachelor of Science degree in Chemistry from the University of Toledo in 1970, and a doctoral degree in Analytical Chemistry from Wayne State University in 1975. He has worked as the Forensic Director of the Quest facility in Van Nuys, California since 1995. In this capacity, Dr. Jambour has been responsible for the operation of Quest's substance

[8] Another form of Fentanyl comes in a vial with a rubber stopper that is punctured with a syringe. Respondent testified he used glass ampules in December 2007.

abuse testing laboratory, which is certified by the Department of Health and Human Services and the College of American Pathologists to perform forensic urine drug testing. His duties include assurance of accurate results and reports, method development and validation, and quality assurance. Dr. Jambour has over thirty years of experience working in toxicology research and managing forensic laboratories. Respondent stipulated to Dr. Jambour's expertise as a forensic toxicologist.

In this matter, Quest's summary, reports and laboratory documents relating to the analysis of respondent's December 19, 2007, urine sample were certified by its Norristown, Pennsylvania Operations Director, Susan Mills. Dr. Jambour discussed this case with Ms. Mills extensively, and comprehensively reviewed all documents related to this testing. Based upon this information, Dr. Jambour testified for the Board regarding Quest's procedures and test results for respondent's December 19, 2007 urine sample (hereafter, specimen or sample). Dr. Jambour's testimony is paraphrased in relevant part as follows.

December 2007 Analysis: In December 20007, respondent's urine sample was subjected to comprehensive medical professional panel batch testing designed to detect a wide array of drugs. Due to the profound effects positive test results can have on these individuals' livelihoods, Quest is committed to ensuring that false positive results are not reported. There are national threshold standards for determining the presence of common drugs of abuse, such as marijuana, amphetamine, and methamphetamine; thresholds for other drugs are established by the laboratory.

Quest's qualitative threshold for a positive finding of Fentanyl with ELIZA assay was 300 picograms. This initial screening test was confirmed by the more specific GC/MS analysis, which has a higher threshold of 500 pg/mL and examines the specimen's molecular structure. Fentanyl is an opioid: a synthetic compound which acts like an opiate. There is no other chemical substance that mimics Fentanyl in a laboratory testing when broken down to the molecular level. For this reason, a positive result for the presence of Fentanyl means, with complete certainty, that Fentanyl is present in the sample. After testing positive on the ELIZA screen, respondent's GC/MS quantitative Fentanyl result was measured as 622 pc/mL.

Dr. Jambour emphasized that this was "not an incidental finding." Fentanyl is the most potent opioid, one thousand times more potent than morphine. It metabolizes quickly and rapidly leaves the body. Only small amounts of this drug are taken; consequently, it can be detected in the body after three days "at the outside." The presence of the antagonist Naltrexone and its metabolite in respondent's sample was confirmed by four separate GC/MS tests. In Dr. Jambour's opinion, the level of Naltrexone in respondent's specimen was consistent with someone who had ingested the drug on the day of collection, December 19, 2007.

November 2008 Retest: Norfentanyl is the metabolite for Fentanyl which indicates that the substance has passed through the subject's liver. When Quest tested another aliquot of respondent's urine for Fentanyl and Norfentanyl in November 2008, the lower quantity of Fentanyl found (568 pg/mL) was within the normal analytical variation allowed by the federal government. The amount of Norfentanyl present was consistent with the level of Fentanyl, indicating ingestion within the last one to three days.

Quest's failure to test respondent's sample for the presence of Fentanyl's metabolite in December 2007 does not invalidate the test results in either the December 29, 2007 or June 26, 2009 Laboratory Reports. Dr. Jambour testified that GC/MS does not test for Norfentanyl. The instrumentation necessary to test for this metabolite is known as Liquid Chromatography/Mass Spectrometry or LCMS, which has greater sensitivity for this substance than the GC/MS. Dr. Jambour agreed that it is always a good idea to test for both a compound and its metabolite at the outset; however, this was not done in December 2007 because Norristown Quest had the LCMS, but it did not have the time available on this instrument to run the metabolite test. Dr. Jabour further indicated that, by November 2008, Quest had established a new analysis for determining the presence of Norfentanyl. It tested another aliquot of respondent's sample using LCMS because it was "a new toy to play with" and it is always beneficial to have additional validation samples. If this retest had not detected the presence of Norfentanyl, thereby indicating that Fentanyl had not been processed by respondent's liver, Quest would have reported this result to the Board because it would have cast "serious doubt" on the initial testing. Because the result was consistent with the previously reported result, Quest did not inform the Board of this new result. Quest produced these results in its June 26, 2009 report, after the Board requested testing for Fentanyl metabolite. A new test was not run at the time due to concern about the sufficiency of the remaining sample.

Based upon his review of all laboratory data, as well as Quest's Final Laboratory Reports dated December 29, 2007 and June 26, 2009, Dr. Jambour concluded that respondent's urine sample was clearly positive for Fentanyl, Norfentanyl, Naltrexone and Naltrexone's metabolite.

"Splash" theory: Fentanyl is manufactured in a powder form. It is available as a skin patch designed to deliver small doses through the skin, or in a lollipop form. In a surgical setting, Fentanyl is typically administered as a liquid, dissolved in water for fluid injection into an IV. As an injectable liquid, Fentanyl typically comes in a vial. In Dr. Jambour's opinion, it is not possible for an anesthesiologist who is not wearing gloves to ingest enough Fentanyl through the skin to have a detectable, positive drug test. While Fentanyl will absorb through the skin when prepared as a skin patch, the patch contains a gel which allows the drug to be transferred through the skin. In his opinion as a chemist, it its "inconceivable" that an aqueous solution could be carried through the skin. Dr. Jambour testified that there is no literature to support skin absorption of Fentanyl from a spill. This opinion was based upon a

"quick Google search." In his opinion, the reason respondent's December 19, 2007, urine sample tested positive for Fentanyl was that respondent had intentionally ingested this controlled substance.

Presence of Naltrexone Does Not Negate Intentional Ingestion: Based upon his experience and knowledge of professional literature, Dr. Jambour's expertise includes how long drugs remain present in the body. Dr. Jambour estimated that both Naltrexone and Fentanyl can be detected in a urine specimen at least three days after the person has taken the drug. On further examination, Dr. Jambour estimated that the sample would test negative for Naltrexone and its metabolite within a maximum of four days "at the very outside."

Naltrexone is designed to override the "high" produced by taking Fentanyl. In Dr. Jambour's opinion, it is possible for respondent's urine to test positive for both Fentanyl and Naltrexone. For example, respondent could take Fentanyl on one day and Naltrexone on the next day. Both substances would be positive in a urine sample taken on the third day. As a result, even though respondent's December 19, 2007 urine sample was positive for both substances, it does not preclude respondent's recreational use of Fentanyl.

17. *Testimony of Charles Wilcox*: Charles Wilcox received his Bachelor of Science degree in microbiology/medical technology in 1963 from San Diego State University. He then worked in a variety of medical settings as a medical technologist or chief technologist. Since 1995, Mr. Wilcox has been employed as a forensic toxicologist at Utica Toxicology Services (Utica), a two-man operation based in Chula Vista, California. His duties include forensic alcohol analysis of blood, breath and urine, urine drug screenings, consultations with attorneys on alcohol and drug cases involving driving under the influence of alcohol or drugs (DUI). Mr. Wilcox has actively participated in continuing professional development courses. A large percentage of his practice (60 percent) and ongoing education relates to DUI cases involving alcohol or drugs such as methamphetamines, cannabis, and/or cocaine. Mr. Wilcox has testified exclusively as a defense expert in over one thousand alcohol-related Department of Motor Vehicles (DMV) hearings, as well as before the superior court. He agreed he was a "professional expert." He has never testified in a case where a defendant was accused of driving under the influence of Fentanyl.

Mr. Wilcox reviewed a transcript of Dr. Jambour's testimony in this matter and considered it in light of respondent's position that his positive test was the result of a "splash" of Fentanyl received on December 19, 2007 while he was in the operating room. Mr. Wilcox's testimony is summarized in relevant part as follows.

Mr. Wilcox disagreed with Dr. Jambour's statement that it is not possible for Fentanyl to be absorbed through the skin in its aqueous form. Mr. Wilcox conducted a literature search and located articles stating that Fentanyl can be absorbed through the skin in its aqueous form in the operating room when handled by anesthesiologists

and or by touching the table in the operating room or other surfaces. Other articles report that pharmaceutical workers can inhale Fentanyl powder during the manufacturing process.

The amount of Fentanyl in respondent's urine, as reported in Quest's December 29, 2007 Laboratory Report, was 622 picograms. This is a "very small amount" of Fentanyl, consistent with incidental contact like handling a vial. In Mr. Wilcox's opinion, this quantity of Fentanyl in respondent's sample was less than a "therapeutic dose" for pain or euphoria. He agreed that it was not possible to determine the amount of the original dose of Fentanyl from the report's finding of 622 picograms or when it was ingested, and that the detectable amount of Fentanyl would lessen over time as it was metabolized and excreted. On cross examination, Mr. Wilcox agreed that respondent would have had a negative test for Fentanyl if he had less than 500 picograms/mL in his system at the time of the urine draw.

Mr. Wilcox testified that there were only two explanations for the presence of Fentanyl in respondent's urine sample: (1) because he was inadvertently contaminated by a splash; or (2) because he actively injected or ingested it.[9] Mr. Wilcox candidly testified that he could not say that one explanation was more likely than the other. He had no way of knowing whether respondent had actually handled Fentanyl on December 19, 2007. Before being contacted by respondent, Mr. Wilcox had never considered the novel question of whether Fentanyl in an aqueous solution can be absorbed through the skin. He was unsure of its form during the manufacture process. He believes Fentanyl can be absorbed in the skin in its aqueous form, based upon the literature discussed below and a brief email conversation with a forensic toxicologist.

Mr. Wilcox testified that the creatinine level of respondent's urine was 151.1 mL/dL; this measurement is slightly above average indicating that his urine was slightly concentrated. In Mr. Wilcox's experience, this indicates that respondent had not over-hydrated himself in an effort to hide or dilute out any drugs in his system.

18. *Discussion:* There was no documentary evidence that respondent actually handled Fentanyl on December 19, 2007. Based solely upon his general practice, respondent testified that he handled Fentanyl on this date and that it "just somehow" got into his system.

Several of the articles produced by Mr. Wilcox and respondent shed some light on occupational exposure to Fentanyl through contact with it in operating rooms and during the manufacturing process. For example, Fentanyl has been detected on operating room surfaces and contamination splash on exposed skin is noted as a

[9] On learning of the results of the November 2008 retest, Mr. Wilcox abandoned his original theory that the sample was contaminated because it did not show that the Fentanyl had been metabolized by respondent.

possibility when vials are opened by physicians in the operating room. One article suggested that environmental exposure may be a factor in the etiology of addiction, including relapse. ("Further Evidence of Second-hand Exposure to Drugs in the Operating Room," Goldberger, et al., Society for Neuroscience 36th Annual Meeting, Atlanta, Georgia, October 18, 2006.) Another article opined that the inflated rates of opioid addiction among anesthesiologists may be attributable to their chronic exposures to low doses of aerosolized agents in operating rooms, which results in "neurobiological sensitization to the reinforcing effects of these substances, making later addiction more likely." (*Journal of Addictive Diseases*, "Fentanyl and Propofol Exposure in the Operating Room: Sensitization Hypotheses and Further Data," Vol. 27(3) 2008, p. 67.) During the manufacture of Fentanyl, industrial workers are subject to dust particles from Fentanyl's unadulterated powder form, the effects of which were seen in several urine samples at unspecified levels. (*Annals of Occupational Hygiene*, "Identification of Exposure Pathways for Opioid Narcotic Analgesics in Pharmaceutical Production Workers," Vol. 50, pp. 665-677.) As conceded by Mr. Wilcox, Fentanyl in its powder form is much more concentrated than it is once it is placed in an aqueous form.

These articles do not establish that a detectable level of Fentanyl, sufficient to result in a positive urine test which exceeds the thresholds for both ELIZA and GC/MS testing, can result from dermal absorption after an inadvertent Fentanyl "splash."[10] In fact, Mr. Wilcox agreed that these articles did not find detectable Fentanyl levels in urine from incidental contact on skin or during the provision of surgical services, and that he did not locate any other articles that supported this assertion. Mr. Wilcox found no studies in the literature where incidental contact with liquid Fentanyl resulted in a detectable amount of Fentanyl in the urine.

19. *Credibility*: Based upon his training, experience, and review of the December 29, 2007 and June 26, 2009, Laboratory Reports and underlying test documentation, Dr. Jambour's testimony that respondent actively ingested Fentanyl on December 19, 2007, is determined to be credible and more persuasive than that of Mr. Wilcox.

Dr. Jambour's strong belief in the accuracy of Quest's laboratory results does not indicate an impermissible bias as suggested by respondent. Rather, it is reflective of one whose professional duties have consistently involved ensuring accurate testing validation and quality assurance to prevent the issuance of false positive testing results. Mr. Wilcox's testimony did not contradict Dr. Jambour's opinions regarding the validity of the test results, the appropriate thresholds for Fentanyl detection, the length of time Fentanyl and Naltrexone remain detectable in urine, or that their

[10] Respondent's Exhibit K ("Dermal Penetration of Fentanyl: Inter-and Intraindividual Variations," Pharmacology & Toxicology 2003, 93, 244-248) relates solely to in vitro skin absorption of Fentanyl over prolonged time periods (up to 48 hours) and is consequently of no relevance.

overlapping presence in the December 19, 2007 specimen does not rule out intentional ingestion. Mr. Wilcox's sole point of disagreement with Dr. Jambour was on the viability of the "splash" theory as an explanation for respondent's positive Fentanyl test. Dr. Jambour did not conduct a thorough literature search. Nevertheless, the articles offered by respondent through Mr. Wilcox do not weaken Dr. Jambour's opinion that respondent's test results are not due to incidental splash contamination absorbed through the skin.

Respondent's testimony that he did not actively ingest Fentanyl on or before December 19, 2007 and that it just somehow got into his system is not credible. Respondent's own testimony, that Fentanyl splashes are "minimal" and will not cause a therapeutic blood level, is consistent with that of Dr. Jambour. While respondent's sample was also positive for Natrexone, respondent's historic difficulty in consistently taking Naltrexone demonstrates that he is able to manipulate his Naltrexone usage. Unlike previous instances after being informed of a positive test, respondent offered no explanations, raised no questions about accidental exposure to Fentanyl, and did not request any independent testing. Instead, respondent refused to submit to testing on January 2, 2008, submitted his letter of resignation, and refused to cooperate with SJGH's investigation after it was informed of this test result by Diversion. Respondent's conduct was inconsistent with that of an individual genuinely seeking resolution of a perceived error.

Evidence in Aggravation/Mitigation

20. During his nearly five years in Diversion, respondent had four random drug tests each month. With the exception of the December 19, 2007 test, none of these approximately 240 random drug tests was positive for Fentanyl. The three positive tests for amphetamine and/or methamphetamine were accepted by the DEC as being attributable to respondent's body building supplements. As indicated by Mr. Valine, respondent's positive Fentanyl test is consistent with a relapse, which is an expected part of the recovery process.

21. Respondent testified that he learned a great deal about himself from his participation in Diversion. He continues to attend NA meetings, and typically attends once every week or 10 days.

22. *Respondent's Current Employment*: Since February 2008, respondent has worked as an independent contractor anesthesiologist at two outpatient ambulatory surgery centers: San Ramon Surgery Center and Tri-Valley Outpatient Surgery Center, in Pleasanton, California (Centers). There are five facilities where surgeries are performed. Respondent's work schedule with the Surgery Centers may include procedures at multiple centers in a day.

Robin Dennings, M.D., is the chief anesthesiologist for the Centers and respondent's supervisor. Julie Ferguson is the administrator for the Centers. Both individuals testified that respondent appears to be a very honest person.

23. At hearing, Dr. Dennings testified that he has known respondent for a year and a half. Respondent told him about his participation in Diversion, that he had a positive Fentanyl test, that Diversion wanted to extend respondent's participation in the program and that respondent contested this.

In contrast to this testimony, in April 2008, Dr. Dennings advised the Board's Senior Investigator Ms. Vanderveen that respondent went through a certification process before he began rendering services at the Centers. During this process, respondent did not reveal that he had a history of Fentanyl problems or had participated in Diversion. Dr. Dennings indicated that not too many narcotics are kept on hand at the surgery centers; however, Fentanyl is available and used in small quantities. Due to the small amount of drugs kept at the surgery centers, Dr. Dennings believed that it would be quickly obvious if anyone were abusing Fentanyl.

24. Ms. Ferguson also testified that respondent disclosed his participation in Diversion and his positive test result that led to this case. With this knowledge, respondent's clinical behavior has been monitored. Ms. Ferguson has never found any discrepancies in respondent's narcotic counts.

LEGAL CONCLUSIONS

1. In this action to revoke respondent's medical license, complainant bears the burden of proof on the charges alleged in the Accusation. The standard of proof is clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.) Clear and convincing evidence requires a finding of high probability or evidence so clear as to leave no substantial doubt and sufficiently strong as to command the unhesitating assent of every reasonable mind. (*In re Michael G.* (1998) 63 Cal.App.4th 700, 709, fn. 6.)

2. Under the Medical Practice Act (Act), Business and Professions Code section 2000 et seq., "[p]rotection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." (§§ 2001.1, 2229.)

Pursuant to section 2227, following a hearing, the license of a physician who has been determined to have violated the Act may be revoked, suspended, or placed on probation with appropriate conditions. When considering license discipline, the

protection of the public includes the prevention of future harm. (*Medical Board of California v. Superior Court* (2003) 111 Cal.App. 4th 163 [holding that the Board may not revoke or suspend a license based upon failure to complete the Board's diversion program where the circumstances of the physician's termination from diversion do not otherwise evidence unprofessional conduct or impairment by clear and convincing evidence].)

3. *Unprofessional Conduct*: The Board is required to take action against any licensee who is charged with "unprofessional conduct." (§ 2234.) Pursuant to section 2234, subdivision (a), unprofessional conduct includes "but is not limited to, "[v]iolating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter."

4. Section 2238 provides that a "violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

5. Section 2239, subdivision (a), provides that the "use or prescribing for or administering to himself ...of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely . . . constitutes unprofessional conduct. . ."

6. Pursuant to section 4022, the term "dangerous drug" means "any drug ... unsafe for self-use in humans or animals, including drugs bearing the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import" and "any other drug ... that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006." (§ 4022, subd. (a), (c).)

7. Health and Safety Code section 11170 provides that "No person shall prescribe, administer, or furnish a controlled substance for himself." Section 4021 defines "controlled substance" to mean "any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code." Fentanyl and Sufentanyl are Schedule II controlled substances. (Health & Safety Code § 11055 (c)(8), (25).)

8. As set forth in the Factual Findings and Legal Conclusions as a whole, and particularly in Factual Findings 12, 13, 14, 16, 18, and 19, the Board has met its burden of proof and legal cause is established to revoke respondent's license for violation of Business and Professions Code sections 2234, subdivision (a), 2238 and 2239, subdivision (a), in conjunction with Health and Safety Code sections 11170 and 11055, subdivision (c).

9. As set forth in the Factual Findings and Legal Conclusions as a whole, in light of this relapse, respondent's ability to safely practice as an anesthesiologist is questionable. However, as further indicated particularly in Factual Findings 20 through 24, it would not be contrary to the public interest to place respondent upon probation subject to the terms and conditions outlined below, which include suspension from practice pending further evaluation.

ORDER

Certificate No. G 75023 issued to respondent Louis James Nitsos, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for five (5) years upon the following terms and conditions.

1. *Actual Suspension (Optional Condition 4):* As part of probation, respondent is suspended from the practice of medicine, beginning with the sixteenth (16th) day after the effective date of this decision, pending further notice and written approval by the Board as outlined in paragraphs 2, 8, and 9 below.

2. *Controlled Substances - Total Restriction (Optional Condition 5):* Respondent shall not order, prescribe, dispense, administer, or possess any controlled substances as defined in the California Uniform Controlled Substances Act, pending written approval by the Board.

3. *Controlled Substances - Surrender of DEA Permit (Optional Condition 6):* Within thirty (30) days of the effective date of this decision, respondent shall provide documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

4. *Controlled Substances - Abstain From Use (Optional Condition 9):* Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawful prescription medications, respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name and strength; and issuing pharmacy name, address, and telephone number.

5. *Alcohol - Abstain From Use (Optional Condition 10):* Respondent shall abstain completely from the use of products or beverages containing alcohol.

6. *Biological Fluid Testing (Optional Condition 11):* Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. Prior to practicing medicine, respondent shall, at respondent's expense, contract with a laboratory or service - approved in advance by the Board or its designee - that will conduct random, unannounced, observed, urine testing a minimum of four times each month. The contract shall require results of the urine tests to be transmitted by the laboratory or service directly to Board or its designee within four hours of the results becoming available. Failure to maintain this laboratory or service during the period of probation is a violation of probation. A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent. Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation.

7. *Ethics Course (Optional Condition 16):* Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

8. *Clinical Training Program (Optional Condition 18):* Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which

respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing, except that respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

9. *Psychotherapy (Optional Condition 21):* Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. **The evaluation report shall address respondent's ability to safely practice as an anesthesiologist.** Respondent shall cooperate in providing the psychotherapist any information and

documents that the psychotherapist may deem pertinent. **Respondent shall not practice medicine until the evaluation report has been provided to the Board and respondent has been notified by the Board or its designee in writing.**

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations. Failure to undergo and continue psychotherapy treatment, or comply with any required modification in the frequency of psychotherapy, is a violation of probation.

10. *Notification (Condition 27):* Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

11. *Supervision of Physician Assistants (Condition 27):* During probation, respondent is prohibited from supervising physician assistants.

12. *Obey All Laws (Condition 29):* Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

13. *Quarterly Declarations (Condition 30):* Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

14. *Probation Unit Compliance (Condition 31):* Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

15. *Interview with the Board or its Designee (Condition 32):* Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

16. *Residing or Practicing Out-of-State (Condition 33):* In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

17. *Failure to Practice Medicine - California Resident (Condition 34):* In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

18. *Violation of Probation (Condition 36):* Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

19. *License Surrender (Condition 38):* Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

20. *Probation Monitoring Costs (Condition 39):* Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

21. *Completion of Probation (Condition 35):* Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

DATED: February 16, 2010

MARILYN A. WOOLLARD
Administrative Law Judge
Office of Administrative Hearings

EDMUND G. BROWN JR., Attorney General
of the State of California
GAIL M. HEPPELL
Supervising Deputy Attorney General
DIAN MAUREEN VORTERS, State Bar No. 190350
Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 322-8311
Facsimile: (916) 327-2247

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LOUIS JAMES NITSOS, M.D.** **824 Griffon Court** **Danville, California 94506** Physician and Surgeon's Certificate No. G 75023 Respondent.	Case No. 02-2008-189113 **ACCUSATION**

Complainant alleges:

PARTIES

1. Barbara Johnston (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about August 25, 1992, the Medical Board of California issued Physician and Surgeon's Certificate Number G 75023 to LOUIS JAMES NITSOS, M.D. (Respondent). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2010, unless renewed.

//

//

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Business and Professions Code (hereinafter "Code") section 2227 provides, in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Code section 2238 states, "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

6. Code section 2239 provides, in pertinent part, that the use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct.

7. Code section 4021 states, "Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

8. Code section 4022 provides, in pertinent part, that a "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Section 11170 of the Health and Safety Code states that "No person shall prescribe, administer, or furnish a controlled substance for himself."

10. Respondent has engaged in conduct constituting violations of the Medical Practices Act, specifically Code sections 2234 (a), 2238 and 2239 (a), in conjunction with Health and Safety Code sections 11170 and 11055 (c), and is subject to discipline pursuant to Code section 2227, as set forth in more particularity below.

FIRST CAUSE FOR DISCIPLINE
(Violations of Drug Statutes)
[Bus. & Prof. Code § 2238; Health & Safety Code § 11170]

11. In March 2002, Respondent's employer, the Metropolitan Anesthesia Consultants Group, placed him on probation after a pharmacist reported higher than normal use of Sufentanil from Respondent's drug kit.

12. On or about January 16, 2003, Respondent referred himself to the Medical Board of California (MBC) Physician Diversion Program (hereinafter "Diversion"). In his Diversion Application he disclosed daily abuse of controlled substances (Sufentanil and Fentanyl) since approximately November 2001. Sufentanil and Fentanyl are Schedule II Controlled Substances under Health and Safety Code, § 11055 (c)(8) and (25).

13. The Diversion program referred Respondent to residential treatment. Respondent received treatment at the Betty Ford Center from January 27, 2003 to May 5, 2003.

14. On or about July 9, 2003, Respondent signed the Physician Diversion Program Agreement. The terms and conditions of the Diversion Program included attendance at recovery groups, abstinence from alcohol and non-approved drugs and biological fluid testing. Respondent was also required to begin taking Naltrexone[1] two weeks prior to returning to work.

15. Between January 2003 to June 2005, Respondent remained unemployed.

---

1. Naltrexone is an opiate antagonist used primarily in the management of alcohol and opiate dependence.

On or about June 27, 2005, he resumed work as an anesthesiologist with work site monitoring at Dameron Hospital in Stockton, California. Since that time, Respondent has continued to work as an anesthesiologist at hospitals in Southern and Northern California.

16. On December 19, 2007, Respondent submitted a urinalysis test which was confirmed positive for Fentanyl (urine level 622 pg/mL; cut off 500 pg/mL) and Naltrexone.

17. On January 2, 2008, Respondent was asked by the Diversion Program to submit a urine sample. Respondent refused to comply with the request to test. On that same date, Respondent submitted a letter of resignation to the Diversion Program. On January 3, 2008, Respondent was terminated from Diversion for reasons other than successful completion of the program.

18. Respondent is subject to disciplinary action under § 2238 in conjunction with Health and Safety Code, § 11170, in that on or about December 19, 2007, he administered or furnished to himself Fentanyl, a Schedule II Controlled Substance (Health and Safety Code, §11055 (c)(8)).

SECOND CAUSE FOR DISCIPLINE
(Self Use of Controlled Substances)
[Bus. & Prof. Code § 2239 (a)]

19. Complainant re-alleges paragraphs 11 through 18 as if fully set forth herein.

20. Respondent is subject to disciplinary action under § 2239 (a) of the Code in that on or about December 19, 2007, he used or administered to himself Fentanyl, a Schedule II Controlled Substance (Health and Safety Code, §11055 (c)(8)).

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number G 75023, issued to Louis James Nitsos;

2. Revoking, suspending or denying approval of Louis James Nitsos' authority to supervised physician's assistants, pursuant to §3527 of the Code;

3. Ordering Respondent to pay the costs for probation monitoring if probation is imposed; and

4 Taking such other and further action as deemed necessary and proper.

DATED: June 13, 2008

BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2008302771
30468350.wpd